Editorial Column

Delays in Treatment for Mental Disorders and Health Insurance Coverage

Wang et al. (2004) present interesting information about the frequent and lengthy delays in receiving treatment experienced by many individuals after the onset of a mental disorder. They estimate a median delay of 10 years after onset until the first contact with a general medical doctor and 11 years until the first contact with a psychiatrist. Even though more severe mental disorders were associated with shorter delays, the average delay between onset and first treatment contact for even the most severe disorders was 5 years.

As noted by these authors, there is evidence that delays in treatment can lead to increased morbidity and mortality, including the development of various psychiatric and physical comorbidities and the adoption of life-threatening and life-altering self-treatments (e.g., licit and illicit substance abuse). Beyond appealing to some sense of obligation or desire to provide adequate and timely medical care to individuals suffering from mental disorders, it is also in the nation's financial self-interest to find out the factors influencing the length of the delay.

Wang et al. tested the effect of various individual characteristics, including age, gender, education, and race, on increases or decreases in the length of time before initial contact. Data limitations did not permit them to test for the effect of two other factors likely to be determinants of the timing of contact with a medical professional: income and health insurance coverage. Although education and race are usually correlated with both of these characteristics and therefore may be jointly capturing the effects of income and insurance, the question of the net effect of these two factors remains unanswered. Because affordability of care is one of the few factors private and public policymakers can alter, this is a question worth pursuing.

As most people know, mental health care services are not covered by health insurance packages and health plans to the same degree as physical health care services. Not only are there usually more services excluded as covered benefits, but those services that are covered are often subject to higher co-pays and are capped at a maximum number of covered treatments. Less well known is the fact that those with severe mental illness (SMI) are less likely

to have health insurance coverage of any kind. McAlpine and Mechanic (1999) estimate that while 11.4% of those with no measured mental disorders lack health insurance coverage, 20.4% of those with SMI and 18.2% with less severe mental disorders lack coverage.

Millions of people in the U.S. experience one or more mental health disorder at some time during their lifetime. Nearly one-third of the U.S. population experiences one or more disorder in a year (Kessler et al. 1994). Some conditions and combinations of conditions are more disabling and are likely to have a more pronounced effect on education, income, employment, and other life prospects. Mechanic et al. (2002) show that many individuals with mental health disorders are successful members of the labor force. However, relative to other adults, members of this population group are more likely to be unemployed and thus not eligible for employer sponsored insurance (ESI), the primary source of health insurance for most nonelderly adults. Multivariate studies of labor force outcomes have generally found employment levels to be lower among persons with mental illness (Ettner et al. 1997; Sturm et al. 1999; Mitchell and Anderson 1999; Druss et al. 2001). In addition, adults with SMI are more likely to move in and out of the labor market. Sturm et al. (1999) found that individuals with mental illness are more likely than those without such disorders to leave a job with insurance to become unemployed or exit the labor force.

Mental illness is distinct from many other chronic illnesses in that its onset often occurs during late adolescence or young adulthood. Both the likelihood of having a disorder and the severity of illness correlates with age; both prevalence and severity are greater for younger individuals—especially those aged 25 to 34 years (Kessler et al. 1994). This is the same age group that has the highest level of uninsurance. In part because mental illness often begins during late adolescence or young adulthood, it is more likely to have a greater impact on educational attainment and income than many other chronic conditions. Studies have consistently found there to be a negative correlation between mental illness and income (Frank and McGuire 1999). Ettner et al. (1997) found that among the working population, having a mental illness reduces income substantially for both men and women—an 18% drop for women and a 13% drop for men. Lower levels of education and income are both significant negative predictors of having health insurance coverage.

What emerges is a complex circle of correlation that suggest various paths of causation. Lower levels of employment, educational attainment, and income are positively correlated with both mental illness and the lack of health insurance coverage; lower levels of insurance coverage are negatively

correlated with utilization of primary care; late detection and treatment of mental illness is positively correlated with psychiatric and physical comorbidities; and so on. As noted by others, causation is difficult to establish because we rarely have a controlled experiment (Levy and Meltzer 2004).

Clearly some individuals with SMI enter the medical care system even without health insurance coverage, and some with insurance also experience lengthy delays in treatment. In general, individuals without health insurance coverage are significantly less likely to have a usual source of care or receive routine check-ups and primary care, where both early detection and early treatment could take place (IOM 2001). Instead, the likely point of entry would be the emergency room or a public clinic. Given the level of suicide attempts and substance abuse among those with untreated mental illness, entering the medical care system through these mechanisms in some ways is getting too little care too late. In addition to experiencing psychiatric comorbidities, people with mental illness also tend to be in worse physical health and have more chronic conditions than those with no disorders (Frank and McGuire 1999; McAlpine and Mechanic 2000; Hadley 2002).

Thus, a large body of evidence supports the argument that people with mental illness, especially those with more serious and persistent problems, need access to general health care as well as mental health care. The findings of Wang et al. point to a serious problem in our health care system and underscore the belief of many that mental illness may be one of the more important areas in which the lack of insurance coverage leads to serious deleterious health consequences which impact both the individual and society.

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